211 CMR 66.00: SMALL GROUP HEALTH INSURANCE

Section

66.01: Authority

211 CMR 66.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. chs. 175, 176A, 176B, 176D, 176G, 176I and 176J.

66.02: Purpose

The purpose of 211 CMR 66.00 is to implement the provisions of M.G.L. c. 176J.

66.03: Applicability and Scope

(1) 211 CMR 66.00 applies to all health benefit plans offered, made effective, issued, renewed, delivered or issued for delivery to any eligible small business under M.G.L. c. 176J whether issued directly by a carrier, or through an association or through an intermediary.

(2) Nothing in 211 CMR 66.00 prohibits a carrier that offers health insurance to a business of more than 50 eligible employees from offering insurance in accordance with the provisions of 211 CMR 66.00.

66.04: Definitions

Actuarial Equivalence refers to two health benefit plans which have the same Benefit Level Rate Adjustment factor.

Actuarial Opinion a signed written statement by a qualified member of the American Academy of Actuaries, as prescribed by Appendix A of 211 CMR 66.90, which certifies that the actuarial assumptions, methods and contract forms utilized by the carrier in establishing premium rates for small group health benefit plans comply with all the requirements of 211 CMR 66.00 and any other applicable law.

Adjusted Average Market Premium Price the arithmetic mean of all premium rates for a given prototype plan sold to eligible insureds with similar case characteristics by all carriers selling prototype plans in Massachusetts.

Benefit Level the health benefits provided by, and the benefit payment structure of, a health benefit plan.

Benefit Level Rate Adjustment a number that represents the ratio of the actuarial value of the benefit level of one health benefit plan as compared to the actuarial value of the benefit level of another health benefit plan that is measured on the basis of a group census that is representative of Massachusetts small groups for that carrier.

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Carrier an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175, a non-profit hospital service corporation organized under M.G.L. c. 176A, a non-profit medical service corporation organized under M.G.L. c. 176B, or a health maintenance organization organized under M.G.L. c. 176G, which issues a health benefit plan, including a preferred provider plan issued under M.G.L. c. 176I, to one or more eligible small businesses under M.G.L. c. 176J.

Case Characteristics age, rate basis type, industry, number of eligible persons and participation rate of a group.

Class of Business all or a distinct grouping of eligible insureds as shown on the records of the carrier which is provided with a health benefit plan through a health care delivery system operating under a license distinct from that of another grouping. For the purposes of 211 CMR 66.00, only the following three classes of business shall be recognized: persons covered through plans offered by health maintenance organizations licensed under M.G.L. c. 176G, persons covered through preferred provider plans approved under M.G.L. c. 176I and persons covered through other indemnity plans organized under M.G.L. chs. 175, 176A, and 176B.

Commissioner the commissioner of insurance, or his or her designee.

Eligible Dependent the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee.

Eligible Employee an employee who:

(a) works on a full-time basis with a normal work week of 30 or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business; and provided, however, that “eligible employee” does not include an employee who works on a temporary or substitute basis; and

(b) is hired to work for a period of not less than five months, provided, however, that a carrier cannot require that a person must have worked for an unreasonable length of time in order to qualify as an "eligible employee." For the purposes of 211 CMR 66.00, five months shall be deemed to be an unreasonable length of time when determining "eligible employee."

Eligible Small Business or Group any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed from among one to not more than 50 eligible employees, the majority of whom worked in Massachusetts; provided, however, that the sole proprietorship, firm, corporation, partnership or association need not have been in existence during the preceding year in order to qualify as an "eligible small business or group." In determining the number of eligible employees, companies that are affiliated companies or are eligible to file a combined tax return for purposes of state taxation are considered to be one business. Except as otherwise specifically provided, provisions of 211 CMR 66.00 which apply to an eligible small business will continue to apply through the end of the rating period in which an eligible small business no longer meets the requirements of "eligible small business or group."

Emergency Services covered services provided after the sudden onset of a medical emergency manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in:

(a) placing the patient's health in serious jeopardy;
(b) serious impairment of bodily functions; or
(c) serious dysfunction of any bodily organ or part.

Financial Impairment a condition in which, based on the overall condition of the carrier as determined by the commissioner, the carrier is, or if subjected to the provisions of 211 CMR 66.00 could reasonably be expected to be, insolvent, or otherwise in an unsound financial condition such as to render its further transactions of business hazardous to the public or its policyholders or members, or is compelled to compromise, or attempt to compromise, with its creditors or claimants on the grounds that it is financially unable to pay its claims.

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Group Average Premium Rates a set of numbers, one for each rate basis type, where each number is the total of the premiums charged to an eligible small business for all eligible employees and eligible dependents of that rate basis type, divided by the number of insured eligible employees of that rate basis type.

Group Base Premium Rates the group average premium rates that would be charged by a carrier at the beginning of the rating period if the premiums were based solely upon the age, industry, group size, participation rate, and rate basis type of the members of the group. The group base premium rates for every group will be adjusted to a January first basis by dividing each group base premium rate by a deflator. The deflator equals the sum of trend for that carrier and the number one, raised to the power of the fraction of the calendar year which has elapsed at the time the new rating period begins.

Health Benefit Plan any general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175; a group hospital or medical service plan issued under M.G.L. c. 176A or M.G.L. c. 176B; a group health maintenance contract issued by an HMO under M.G.L. c. 176G; a preferred provider plan issued under M.G.L. c. 176I; and any multiple employer welfare arrangement (MEWA) required to be licensed under M.G.L. c. 175; offered to an eligible small business. The term "health benefit plan" does not include accident only, credit, dental, vision, long-term care only or disability income insurance, coverage issued as a supplement to liability insurance, insurance arising out of a worker's compensation or similar law, automobile medical payment insurance, insurance under which beneficiaries are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance, or any group blanket or general policy which provides supplemental coverage to Medicare or other governmental programs.

Health Maintenance Organization or HMO an entity licensed to do business in Massachusetts under M.G.L. c. 176G.

Insured any policyholder, certificateholder, subscriber, member or other person on whose behalf the carrier is obligated to pay for and/or provide health care services.

Intermediary a chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance, which has complied with the requirements of 211 CMR 66.13(3), and which offers its members the option of purchasing a health benefit plan.

Late Enrollee an eligible employee or dependent who requests enrollment in an eligible small business' health insurance plan or insurance arrangement after the group's initial enrollment period, his or her initial eligibility date provided under the terms of the plan or arrangement, or the group's annual open enrollment period.

Mandated Benefit a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan.

MEWA or Multiple Employer Welfare Arrangement or Multiple Employer Trust either:

(a) a fully-insured multiple employer welfare arrangement as defined in sections 3 and 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC 1002 and 1144, as amended; or

(b) an entity holding itself out to be a MEWA, multiple employer welfare arrangement or multiple employer trust which is not fully insured and, therefore, shall be required to be licensed under M.G.L. c. 175. An arrangement that constitutes a MEWA is considered a separate group health plan with respect to each employer maintaining the agreement.

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Participation Rate the percentage of eligible employees electing to participate in a health benefit plan out of all eligible employees, or the percentage of the sum of eligible employees and eligible dependents electing to participate in a health benefit plan out of the sum of all eligible employees and eligible dependents, at the election of the carrier. In either case, the numbers used to compute these percentages may not include any eligible employee or eligible dependent who does not participate in the eligible small business' health benefit plan, but who is enrolled in another health benefit plan as a spouse or dependent.

Participation Requirement a policy provision, or a carrier's underwriting guideline if there is no such policy provision, that requires that a group attain a certain participation rate in order for a carrier to accept the group for enrollment in the health benefit plan. For groups of five or fewer eligible persons, a carrier may require a participation rate not to exceed 100%. For groups of six or more eligible persons, a carrier may require a participation rate not to exceed 75%.

Pre-existing Conditions Provision a health benefit plan provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received; or as to a pregnancy existing on the effective date of the coverage.

Prototype Plan a health benefit plan offered by an HMO in accordance with 211 CMR 66.05(1)(k) and 211 CMR 66.11.

Qualifying Health Plan any blanket or general policy of medical, surgical or hospital insurance described in M.G.L. c. 175, § 110(A), (C) or (D); policy of accident or sickness insurance as described in M.G.L. c. 175, §108 which provides hospital or surgical expense coverage; nongroup or group hospital or medical service plan issued by a non-profit hospital or medical service corporation under M.G.L. c. 176A and c. 176B; nongroup or group health maintenance contract issued by an HMO under M.G.L. c. 176G; nongroup or group preferred provider plan issued under M.G.L. c. 176I; self-insured or self-funded health plans offered by an employer or union health and welfare fund; health coverage provided to persons serving in the armed forces of the United States; or government-sponsored health coverage including but not limited to Medicare and medical assistance provided under M.G.L. c. 118E.

Rate Basis Type each category of individual or family composition for which a carrier charges separate rates. For the purpose of 211 CMR 66.00, carriers may use the following categories:

(a) individual;
(b) two adults;
(c) one adult and one or more children; and
(d) two adults and one or more children.

Nothing in 211 CMR 66.04: Rate Basis Type prohibits a carrier from establishing separate rates for active employees and retirees, or for Medicare-eligible insureds, or for any other categories to the extent otherwise required by state or federal law, such as persons for continued group health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or M.G.L. c. 176J, § 9.

Rating Period the period for which premium rates established by a carrier are in effect, as determined by the carrier.

Trend the annual change, from the first day of a group's prior rating period to the first day of that group's new rating period, in the average of all groups' base premium rates attributable to factors other than changes in benefit levels and case characteristics, adjusted for rating periods greater or lesser than one year.

Waiting Period a period immediately subsequent to the effective date of an insured's coverage under a health benefit plan during which the plan does not pay for some or all hospital or medical expenses.

66.05: Minimum Coverage Standards

(1) Group Offerings.

(a) Unless otherwise provided in 211 CMR 66.05, every carrier must make available to every eligible small business every health benefit plan which it currently makes available to any eligible small business, and must accept for enrollment any eligible small business which seeks to enroll in a health benefit plan. Upon the request of an eligible small business, a carrier must provide that business with a price for every health benefit plan which it currently makes available to any eligible small business, provided, however, that if the carrier has so many health benefit plans currently available that a particular request by an eligible small business is unreasonable, the carrier may provide the eligible small business with prices for a representative sample of health benefit plans which include, but are not limited to, the least and most comprehensive plans currently made available by the carrier.

(b) If a carrier is not accepting every new eligible small business, it may not accept any new eligible small businesses either directly, through an association or through an intermediary. However, if a carrier issued a health insurance product which is not available to eligible small businesses but is available to a group with 51 or more employees and the size of that group declined to 50 or fewer employees during the term of the policy, the carrier is not required to make that particular health insurance product available to eligible small businesses.

(c) A carrier may deny a group of five or fewer eligible employees enrollment in a health benefit plan unless the group enrolls through an intermediary, provided that the carrier complies with all of the following requirements:

1. For groups of five or fewer eligible employees, every carrier must make coverage available either directly or through an intermediary.

2. No carrier may require a group of five or fewer eligible employees to join an intermediary if the intermediary has unreasonable barriers to membership, including, but not limited to, unreasonable fees or unreasonable membership requirements. If a small group is precluded from joining an intermediary due to unreasonable membership barriers, the carrier must enroll the small group directly.

3. If a group of five or fewer eligible employees elects to enroll through an intermediary, a carrier may not deny that group enrollment.

4. The carrier must implement the requirements in 211 CMR 66.05(1)(b) consistently, treating all similarly situated groups in a similar manner.

5. Any carrier which enrolls eligible small businesses through an intermediary must comply with all provisions of 211 CMR 66.00.

6. Nothing in 211 CMR 66.05(1)(c) prohibits an eligible small business with six to 50 employees from electing to enroll through an intermediary for coverage under a health benefit plan.

7. Nothing in 211 CMR 66.05(1)(c) permits a carrier to require an eligible small business with six to 50 employees to enroll through an intermediary for coverage under a health benefit plan.

(d) Carriers are not required to issue a health benefit plan to an eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months the eligible small business has:

1. made at least three or more late payments in a 12 month period; or

2. committed fraud, misrepresented the eligibility of an employee, or misrepresented information necessary to determine group size, group participation rate, or the group premium rate; or

3. failed to comply in a material manner with a health benefit plan provision, including carrier requirements for employer group premium contributions; or

4. been covered by three or more health benefit plans within the same class of business during the four years immediately preceding the date of application for coverage. However, nothing in 211 CMR 66.05(1)(d)4. may be used by a carrier to refuse acceptance of an eligible small business solely because the eligible small business offers multiple health benefit plans at the same time.

5. A carrier may request information from other carriers regarding the items listed in 211 CMR 66.05(1)(d)1. through 4. provided that the request does not violate any applicable state or federal law. The carrier receiving such a request from another carrier may provide the information if the action will not violate any applicable state or federal law.

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(e) A carrier is not required to issue a health benefit plan to an eligible small business if the small business fails to comply with reasonable requests by the carrier for information necessary to verify the business' application for coverage, including but not limited to information regarding the prior health insurance coverage of the eligible small business. Requests for information may also include information reasonably necessary for the carrier to determine whether the small business is an "eligible small business" or whether a person is an "eligible employee" as defined in 211 CMR 66.04.

(f) A carrier is not required to issue a health benefit plan to an eligible small business if the carrier can demonstrate, to the satisfaction of the commissioner, that the small business fails at the time of issuance or renewal to meet a participation rate or participation requirement as defined in 211 CMR 66.04.

(g) A carrier is not required to issue a health benefit plan to an eligible small business if acceptance of an application or applications would create for the carrier a condition of financial impairment. The carrier must file with the commissioner, at least 30 days in advance of any such denial or as soon as its financial position becomes known to the carrier, a certified statement by an officer attesting to the carrier's overall financial impairment and accompanied by supporting documentation. Any carrier found to be financially impaired by the commissioner must immediately cease issuing policies on an initial basis to eligible small businesses in accordance with the provisions of 211 CMR 66.05(3).

(h) Every carrier must apply participation and employer contribution requirements in a uniform manner to all groups of the same size. Carriers may not increase participation or employer contribution requirements where the size of the group has changed until the group's renewal date of the health benefit plan.

(i) Any carrier who denies coverage to an eligible small business under the provisions of 211 CMR 66.05 must:

1. provide to the small business, in writing, the specific reason(s) for the denial of coverage; and
2. make available to the commissioner, upon request, the documentation for the denial.

(j) An HMO is not required to accept applications from or offer coverage:

1. to a group, where the group is not physically located in the HMO's approved service area; or
2. within an area, where the HMO reasonably anticipates, and receives prior approval by demonstrating to the satisfaction of the commissioner, that it will not, within that area, have the capacity in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing contract holders and enrollees. The HMO may not offer coverage in that area to any new cases of business groups of any size until the later of 90 days after each refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to eligible small business groups.

(k) Notwithstanding any other provision of 211 CMR 66.05, a health maintenance organization must offer coverage or accept applications only for a prototype plan approved according to 211 CMR 66.11; provided, however, that the HMO offers a prototype plan to all eligible small businesses and, provided also, that any non-prototype plans offered selectively to eligible small businesses by the HMO do not contain any pre-existing conditions or waiting periods.

1. A health maintenance organization offering a prototype plan must make coverage available to all eligible persons and all eligible dependents of the eligible small business, except as otherwise provided by 211 CMR 66.05.
2. Any prototype plans offered by an HMO to eligible small businesses shall be subject to all of the requirements of 211 CMR 66.00.
3. An HMO which offers a prototype to new eligible small businesses may not require small business groups in-force as of March 31, 1992 which have a non-prototype plan to downgrade coverage to a prototype plan unless the HMO discontinues selling that particular non-prototype plan to its small and large group businesses.

(2) Eligible Employees and Dependents.

(a) Every carrier must provide coverage to all eligible employees and all eligible dependents within each eligible small business except:

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1. in the case of an HMO, where the eligible employee does not meet the HMO's requirements regarding residence or employment within the HMO's approved service area;

2. in the case of an eligible employee who seeks to enroll in a health benefit plan significantly later than it was initially eligible to enroll. However, an eligible employee or dependent will not be considered a late enrollee if the individual requests enrollment within 30 days after termination of a previous qualifying health plan, and

a. The individual was covered under a previous qualifying health plan at the time of the initial eligibility for the eligible small business' health benefit plan; or

b. The individual lost coverage under the previous qualifying health plan as a result of the termination of his or her spouse's employment or eligibility, death of a spouse, divorce, loss of dependent status or the involuntary termination of the qualifying previous coverage; or

c. A court has ordered coverage be provided for a spouse, former spouse, minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or

d. The loss of prior coverage was due to the insolvency of the former carrier.

(b) A carrier that does not provide coverage to a late entrant because the person did not meet the conditions of 211 CMR 66.05(2)(a)2.a. through d., must make coverage available to that person at the group's next renewal date and may not deny that person coverage at the next renewal date except for reasons otherwise allowed by 211 CMR 66.00.

(c) A carrier may not require that a person must have worked for an unreasonable length of time in order to qualify as an "eligible employee." For the purposes of 211 CMR 66.00, five months is considered to be an unreasonable length of time when determining employee eligibility.

(3) Discontinuance Provisions.

(a) Filing Requirements. Notwithstanding any other provision in 211 CMR 66.05, a carrier may deny a group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible small businesses.

(b) Material to Be Submitted. A carrier that intends to discontinue selling a health benefit plan to new eligible small businesses must, at least 30 days in advance of discontinuing the sale of the health plan, submit to the commissioner a statement certified by an officer of the carrier that specifies all of the following:

1. The date by which it will discontinue selling the health benefit plan to all new groups.
2. The reason(s) for the discontinuance of the health plan.
3. A list of any other health plans it continues to sell in Massachusetts.
4. The number of groups and individuals covered by the discontinued plan, both in Massachusetts and in its total book of business.
5. An acknowledgment that the carrier is prohibited from selling the particular health plan again in Massachusetts to new groups for a period of not less than three years.

(c) Notwithstanding any other provision in 211 CMR 66.05, carriers are permitted to renew coverage, as described in 211 CMR 66.06, under an otherwise discontinued health plan for existing groups.

66.06: Renewability

(1) Every health benefit plan must be renewable with respect to all eligible persons and eligible dependents at the option of the eligible small business except as provided in 211 CMR 66.06(2).

(2) A carrier is not required to renew the health benefit plan of an eligible small business if the small business:

(a) has not paid the required premiums; or,

(b) has committed fraud, misrepresented whether or not a person is an eligible employee, or misrepresented information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or,

66.06: continued

(c) failed to comply in a material manner with health benefit plan provisions, including carrier requirements regarding employer contributions to group premiums; or,
(d) fails, at the time of renewal, to satisfy the definition of an eligible small business or meet the participation requirements of the plan; or,
(e) fails to comply with reasonable requests to verify the information described in 211 CMR 66.05(1)(d); or
(f) is not actively engaged in business.

(3) A carrier must file with the commissioner the criteria it uses under 211 CMR 66.06(2) to determine the nonrenewability of a health benefit plan for an eligible small business as part of the annual filing required by 211 CMR 66.13.

(4) A carrier must provide at least 60 days prior notice to an eligible small business of the carrier's intention not to renew the health benefit plan and the specific reason(s) for the nonrenewal in accordance with the carrier's filed criteria.

(5) A carrier that elects to nonrenew all of its health benefit plans delivered or issued for delivery to eligible small businesses in Massachusetts:
(a) must provide notice of the decision not to renew coverage to all affected eligible small businesses and to the commissioner at least 180 days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under 211 CMR 66.06(5)(a) must be provided at least three working days prior to the notice to the affected small employers; and
(b) after the 180 day notification period, must nonrenew coverage to eligible small businesses only on the date of renewal for each small business; and
(c) is prohibited from writing new business in the small group market in Massachusetts for a period of five years from the date of notice to the commissioner.

(6) Nothing in 211 CMR 66.06 prohibits a carrier from canceling during the term of the policy a health benefit plan issued to an eligible small business for the reasons outlined in 211 CMR 66.06(2)(a), (b), (c) or (f); provided that if the carrier cancels the health benefit plan for the reason found in 211 CMR 66.06(2)(a) during the policy term, a carrier must provide the eligible small business with any grace period as provided in the group's health benefit plan, including any prior notification requirements.

66.07: Pre-existing Conditions and Waiting Periods

(1) No carrier may exclude any eligible employee or eligible dependent from a health benefit plan on the basis of an actual or expected health condition of such person.

(2) No carrier may modify the coverage of an eligible employee or eligible dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(3) No policy may provide pre-existing condition provisions or waiting periods that exclude coverage for a period beyond six months following the individual's effective date of coverage; provided, however, that a carrier may not impose any waiting period upon a new employee who had coverage under a previous qualifying health plan immediately prior to, or until, employment by the eligible small business.

(4) When a group changes from one health benefit plan to another, whether such plan is with the same carrier or a different carrier, the carrier may impose a new waiting period of not more than six months on all members of the group for only those services covered under the new plan that were not covered under the old plan.

66.07: continued

(5) In determining whether a pre-existing condition provision or waiting period applies to an eligible employee or dependent, all health benefit plans must credit the time the person was covered under a previous qualifying health plan if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable services waiting period under the new coverage, and if the previous qualifying coverage was reasonably actuarially equivalent to the new coverage. For the purpose of 211 CMR 66.07(5), "reasonably actuarially equivalent" means the following:

(a) the Benefit Level Rate Adjustment factor for the new health benefit plan is no more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan; provided, however, that if the Benefit Level Rate Adjustment factor for the new health benefit plan is more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan, the eligible employee or dependent must receive at least the benefits of the previous health benefit plan during the term of the pre-existing condition period or waiting period; or

(b) if the previous coverage is under Medicare or Medicaid, the previous coverage is presumed to be reasonably actuarially equivalent to the new health benefit plan.

(6) If a policy includes a waiting period, emergency services must be covered during the waiting period.

(7) Pre-existing conditions clauses and waiting periods must run concurrently and may not extend more than six months beyond the insured's effective date of coverage.

(8) For the purposes of 211 CMR 66.07, “effective date of coverage” is defined as the date the individual is enrolled by the carrier in the health benefit plan.

66.08: Restrictions Relating to Premium Rates

Premiums charged to every eligible small business for health benefit plans issued or renewed, whether through an intermediary, or directly, must satisfy the following requirements:

(1) The Premium Band for Group Base Premium Rates.

(a) For every health benefit plan issued or renewed to an eligible small business, the group base premium rates charged by a carrier to each eligible small business during a rating period may not exceed two times the group base premium rate which could be charged by that carrier to the eligible small business with the lowest group base premium rate for that rate basis type within that class of business.

(b) The carrier shall determine a particular eligible small business' premium to be charged by basing the premium on one or more of the following case characteristics:

1. Age.
2. Industry.
3. Group Size.
   a. The value of a group size rate adjustment may range from 0.95 to 1.05. The group size rating must be based only upon actual administrative costs or other business costs borne by the carrier for serving eligible small businesses of varying sizes and on the number of eligible persons who enroll in the health benefit plan.
   b. If a carrier chooses to establish group size rate adjustments, it must apply the adjustment to every eligible small business.
4. Participation-Rate Rate Adjustment.
   a. A carrier may establish participation-rate rate adjustments for any health benefit plan or plans for any ranges of participation rates below the following minimum participation requirements:
      i. For groups of five or fewer: not to exceed 100%.
      ii. For groups of six or more: not to exceed 75%.

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b. The participation-rate rate adjustments must be based upon sound analysis of the differences in the experience of eligible small businesses with different participation rates.

c. If a carrier chooses to establish participation-rate rate adjustments, it must apply the adjustment to every eligible small business within the ranges defined by the carrier.

5. Any surcharge or rate adjustment for the "Massachusetts Small Employer Health Reinsurance Plan" established under M.G.L. c. 176J, § 8 must be included in the premium band for Group Base Premium Rates. However, a carrier may not charge an eligible small business an amount for the surcharge which exceeds the reinsurance premium for that eligible small business.

(2) Additional Rate Adjustments.

(a) Benefit Level Rate Adjustment.

1. A carrier may establish a benefit level rate adjustment for all eligible small businesses that represents the ratio of the actuarial value of the benefit level of one health benefit plan as compared to the actuarial value of the benefit level of another health benefit plan, measured on the basis of a group census that is representative of Massachusetts eligible small businesses for that carrier.

2. If a carrier chooses to establish benefit level rate adjustments, it must apply the adjustment to every eligible small business.

(b) Area Rate Adjustments.

1. A carrier may establish an area rate adjustment for each distinct region in 211 CMR 66.08(2)(b)2., which shall range from not less than 0.8 to not more than 1.2.

2. The permissible regions are based on the following zip code groupings which refer to the first three digits of the zip code for each eligible small business:

a. 010 through 013
b. 014 through 016
c. 017 and 020
d. 018 through 019
e. 021 through 022 and 024
f. 023 and 027
g. 025 through 026

except that a carrier may combine the zip code groupings outlined in 211 CMR 66.08(2)(b)2.c. and d. into one region or combine the zip code groupings outlined in 211 CMR 66.08(2)(b)2.c., d. and e. into one region for all of its health benefit plans subject to 211 CMR 66.00, or use regions based on groupings of counties that roughly approximate the zip code groupings.

3. If a carrier chooses to establish area rate adjustments, it must apply the adjustments to every eligible small business within each area.

(c) Wellness Program Rate Discount. A carrier may establish a wellness program rate discount for any eligible small business which provides employee wellness programs, provided that the carrier includes a description of its wellness program discount with the actuarial filings required in 211 CMR 66.09 and 211 CMR 66.13. The value of the wellness program rate discount may range from 0.95 to 0.99. If a carrier establishes a wellness program rate discount, it must apply the discount to every eligible insured with an eligible wellness program.

(d) Intermediary Discount. If a carrier provides coverage to eligible small businesses through an intermediary, the carrier may apply a discount factor to the total premium for each eligible small business. The factor must be calculated to account only for the savings to the carrier due to the administrative and marketing activities of the intermediary which are related to the purchase of health benefit plans for its members from that carrier. The factor may not be calculated based on the claims experience, duration of coverage, health status or case characteristics of the eligible small businesses enrolled in the carrier's health benefit plan through the intermediary. The discount may be negotiated between the carrier and each individual intermediary according to the range of services offered by each intermediary.

66.08: continued

(3) Phase-out Adjustments. A carrier who, as of August 15, 1996, charged group base premium rates to any group from among 26 to no more than 50 eligible employees that were more than two times the group base premium rates charged by that carrier to any group from among 26 to no more than 50 eligible employees with the lowest group base premium rate for that rate basis type within that class of business may establish a phase-out adjustment for all groups that were charged more than two times such group base premium rate. No carrier may vary its rates by more than such phase-out adjustment or the amount by which it varied its rates due to those factors on August 15, 1996, whichever is less.

(a) Between December 1, 1996 and November 30, 1997, inclusive, the group base premium rate charged by a carrier to any eligible small business with 26 to 50 employees may not exceed four times the group base premium rate charged by that carrier to an eligible small business with 26 to 50 employees with the lowest group premium rate for that rate basis type within that class of business.

(b) Between December 1, 1997 and November 30, 1998, inclusive, the group base premium rate charged by a carrier to any eligible small business with 26 to 50 employees may not exceed three times the group base premium rate charged by that carrier to an eligible small business with 26 to 50 employees with the lowest group premium rate for that rate basis type within that class of business.

(c) Between December 1, 1998 and November 30, 1999, inclusive, the group base premium rate charged by a carrier to any eligible small business with 26 to 50 employees may not exceed two times the group base premium rate charged by that carrier to an eligible small business with 26 to 50 employees with the lowest group premium rate for that rate basis type within that class of business.

(d) No phase-out adjustment shall be permitted after November 30, 1999.

(e) If a carrier chooses to establish phase-out rate adjustments, every group business from 26 to 50 employees that was charged a group base premium rate that was more than two times the group base premium rate charged by that carrier to the group of 26 to 50 eligible employees with the lowest group base premium rate for the rate basis type within that class of business on August 15, 1996 shall be subject to a phase-out rate adjustment. No carrier may apply a phase-out rate adjustment to any other group business of 26 to 50 eligible employees.

(4) Premium Rate Calculation. No carrier may charge a premium rate to an eligible small business which is based upon an eligible small business' health status, duration of coverage, or actual or expected claims experience.

The premium charged by a carrier to each eligible small business on the date the eligible small business' policy is issued or renewed shall be established such that the average premium rates charged for each rate basis type at the beginning of the rating period adjusted to a January 1st basis, equals:

that rate basis type's group base premium rate,
multiplied by the benefit level rate adjustment,
multiplied by the area rate adjustment,
multiplied by the wellness program discount,
multiplied by the phase-out adjustment,
as may be applicable pursuant to 211 CMR 66.08.

66.09: Actuarial Filings

(1) Every carrier, as a condition of doing business under M.G.L. c. 176J and 211 CMR 66.00, must file an actuarial opinion as set forth in 211 CMR 66.90: *Appendix A* that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J and 211 CMR 66.00.

(2) Every carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 66.00. This information must be made available to the commissioner upon request, but will remain confidential.

66.10: Eligibility Criteria: Exclusion/Limitation of Mandated Benefits in Health Benefit Plans

(1) Notwithstanding any law to the contrary, carriers may offer to eligible small businesses health benefit plans that exclude some or all mandated benefits, provided, however, that carriers offer such health benefit plans only to eligible small businesses which did not provide health insurance to their employees as of April 1, 1992.

(2) Notwithstanding 211 CMR 66.10(1), all health benefit plans offered to eligible small business must include the following:

(a) dependent coverage for newborn infants, adoptive children and newborn infants of a dependent as described in M.G.L. chs. 175, § 47C, 176A, § 8B, 176B, § 4C and 176G, § 4;

(b) continued health care coverage for divorced or separated spouses as described in M.G.L. chs. 175, § 110I, 176A, § 8F, 176B, § 6B and 176G, § 5A; and

(c) coverage for certain period after insured leaves insured group/limited extension of benefits as described in M.G.L. chs. 175, §§ 110D and 110G, 176A, § 8D, 176B, § 6A and 176G, § 4A.

(3) Carriers may require employers to contribute at least 50% of the health insurance premium for employees where the health benefit plan excludes some or all mandated benefits.

(4) A carrier may not issue or renew coverage for an eligible small business that excludes or limits mandated benefits if the eligible small business has had coverage that excludes or limits mandated benefits which has been in effect for a five year period.

66.11: Health Maintenance Organization Prototypes

30 days prior to offering a prototype plan, an HMO must file a copy with the Division of Insurance for approval by the commissioner. No HMO may offer a prototype plan under 211 CMR 66.00 without prior approval by the Division of Insurance.

66.12: Disclosure

Every carrier must make reasonable disclosure in plain English to prospective small business insureds, as part of its solicitation and sales material, of:

(1) the participation requirements or participation rate adjustments of the carrier with regard to each health benefit plan;

(2) permissible limits on pre-existing conditions and waiting periods;

(3) exclusion or limitation of mandated benefits;

(4) mandatory offer and renewal provisions; and

(5) rating limitations according to 211 CMR 66.08, including the surcharge, if any, that shall be applied if one or more members are covered in the "Massachusetts Small Employer Health Reinsurance Plan" set forth in M.G.L. c. 176J, § 8 and 211 CMR 66.08(1)(b)5.

66.13: Filing and Reporting Requirements

(1) Carriers must file all health plans offered under 211 CMR 66.00 with the Division of Insurance.

(2) Carrier Reporting Requirements. On or before March 31st each year, every carrier doing business under M.G.L. c. 176J and 211 CMR 66.00 must file with the commissioner two copies of a report verified by at least two principal officers and covering its preceding calendar year; provided that, if the commissioner determines that a threat of financial impairment exists to the carrier, he or she may require that the report be made available prior to the March 31st deadline. The report must contain at least the following information in a format specified by the commissioner:

66.13: continued

(a) Number of small group health benefit plans offered in Massachusetts during the preceding calendar year;
(b) Number of eligible employees and eligible dependents, as of the close of the preceding calendar year, who purchase a health benefit plan from the carrier;
(c) Number of eligible employees and eligible dependents, as of the close of the preceding calendar year, who purchase a health benefit plan with limited or no mandated benefits;
(d) A copy of the criteria used to determine the nonrenewability of a health benefit plan for an eligible small business as described in 211 CMR 66.06(2);
(e) A statement as to whether a carrier requires groups of five or fewer eligible employees to enroll through an intermediary. If the carrier requires groups of five or fewer eligible employees to enroll through an intermediary the report must also contain:
1. The name, address and phone number of the intermediary; and
2. The intermediary's membership requirements, including any fees paid by members to join or maintain membership in the intermediary; and
(f) The actuarial opinion described in 211 CMR 66.09 and 211 CMR 66.90.

(3) Intermediary Requirements.
(a) Initial Filing. A carrier may condition the enrollment of a group of five or fewer eligible persons on the group enrolling through an intermediary only if the intermediary has at least 30 days prior to enrolling eligible small businesses filed with the commissioner two copies of a report that contains at least the following information certified by an officer of the organization in a format specified by the commissioner:
1. A narrative description of the intermediary;
2. A copy of the basic organizational documents of the intermediary, such as the articles of incorporation, and amendments thereto;
3. A copy of the bylaws, rules, regulations or other similar documents regulating the conduct of the internal affairs of the intermediary;
4. A copy of the eligibility criteria for persons or groups seeking to join the intermediary, including, but not limited to, the forms that persons or members must complete prior to enrollment in the intermediary;
5. The number of Massachusetts members in the intermediary who buy health insurance through the intermediary, broken out by groups and individuals;
6. A listing of the services, other than health insurance, which the intermediary offers to its members;
7. The fees paid by members to join or maintain membership in the intermediary;
8. A description of each health benefit plan offered by the intermediary to the intermediary's members who are residents of Massachusetts;
9. A statement describing whether the intermediary conditions health benefit plan coverage on health status, claims experience, or duration of coverage since issue; and
10. A statement affirming that the intermediary was not formed for the purposes of obtaining insurance.
(b) Annual Filing. Every intermediary which has met the filing requirements of 211 CMR 66.13(3)(a) must, on or before April 1st of each year, file two copies of a report that contains at least the following information, in a format specified by the Commissioner:
1. The number of Massachusetts members in the organization who buy health insurance through the intermediary, broken out by groups and individuals;
2. A listing of the services, other than health insurance, which the intermediary offers to its members;
3. The fees paid by members to join or maintain membership in the intermediary;
4. A description of each health benefit plan offered by the intermediary to its members who are residents of Massachusetts;
5. A statement describing whether the intermediary conditions health benefit plan coverage on health status, claims experience, or duration of coverage since issue; and
6. A statement affirming that the intermediary was not formed for the purposes of obtaining insurance.
(c) Material changes. Every intermediary must file with the commissioner any material changes to the information on file within 30 days of the changes. Such material changes must be on a statement certified by an officer of the organization.

66.14: Severability

If any section or portion of a section of 211 CMR 66.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 66.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

66.90: Appendix A: Actuarial Opinion

CONTENTS OF ACTUARIAL OPINION TO BE FILED UNDER 211 CMR 66.09

ACTUARIAL OPINION

_____

[For a company actuary]:

[I, _____(name and title of actuary)_____ , am an _____(officer) (employee) _____ of _____(name of insurer)_____ and am a member of the American Academy of Actuaries. I am familiar with the applicable statutory provisions of M.G.L. 176J and 211 CMR 66.00.]

[For a consulting actuary]:

[I, _____(name and title of consulting actuary)____ am associated with the firm of _____ (name of consulting actuarial firm)_____ and am a member of the American Academy of Actuaries. I have been involved in the preparation of the small employer health insurance premium rates of the _____ (name of insurer) _____ and am familiar with the applicable statutory provisions of M.G.L. 176J and 211 CMR 66.00.]

I have examined the actuarial assumptions and actuarial methodologies used by _____ (name of insurer) _____ in setting small employer health insurance premium rates and the procedures used by _(name of insurer)_ in implementing small employer health insurance rating plans. I have used one of the following methods as the basis of my opinion that the premium rates and procedures are in compliance with M.G.L 176J and 211 CMR 66.00 (check box that applies):

[If the actuary examined rating policies and procedures] :

[ ] 1. I determined that nothing in the rating policies and procedures would allow an individual employer group's claim experience, health history, or duration of coverage to be used in a manner that violates the rate restrictions of M.G.L. c. 176J and 211 CMR 66.00.

[If the actuary tested the results of rating procedures on the distribution of rates and renewal increases]:

[ ] 2. I relied on listings and summaries of relevant data prepared by _____ (name and title of company officer responsible for preparing the underlying records if different from the certifying actuary). I tested a sample of groups in each class of business and verified that, after being reclassified to common case characteristics and benefit design characteristics, the resultant rate differences were in compliance with M.G.L. 176J and 211 CMR 66.00.

In other respects, my examination included a review of the actuarial assumptions and actuarial methods and the tests of the actuarial calculations that I considered necessary.

I certify that for the period _____ to _____ the small group health premium rates and rating plan of _____(insurer)_____ met the following requirements:

Check off the boxes to indicate that the carrier's actuarial assumptions, methods and rates comply with the relevant requirements of 211 CMR 66.00 in each specific area. Please use separate sheets for each class of business.

66.90: continued

[ ] Class of business: _____

[ ] Premium band, as specified in 211 CMR 66.08(1)

[ ] Rate basis categories (list):

_____

[ ] Please provide the ratio of the highest to lowest group base premium rate for each rate basis type listed above for the health benefit plan with the greatest premium band differential:

Rate Basis Type Ratio

[ ] Only age, industry, group size, participation rate and "Massachusetts Small Employer Health Reinsurance Plan" rate surcharge are within the premium band specified in 211 CMR 66.08(1)

[ ] Indicate which case characteristics are used in the premium band specified in 211 CMR 66.08(1):

___ Age
___ Participation Rate
___ Industry
___ Group Size
___ Reinsurance

[ ] Additional rate adjustments, as specified in 211 CMR 66.08(2)

[ ] The range of Benefit Level Rate Adjustments is: _____

[ ] The range of Area Rate Adjustments is: _____

[ ] Do the Areas used comply with the areas listed in 211 CMR 66.08(2)(b)2.a. through g. ? (yes or no) ____ If the answer is no, please list the areas used: _____

[ ] The range of the Wellness Discount is: _____

[ ] Phase-out adjustments [for groups with between 26 and 50 eligible employees between December 1, 1996 and November 30, 1999], as specified in 211 CMR 66.08(3)

[ ] The range of the Phase-out Adjustment is: _____

Please provide any further written comments regarding any information or statement made in this certification on separate attached sheets of paper.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

_____ Signature of Actuary

_____ Date

REGULATORY AUTHORITY

211 CMR 66.00: M.G.L. chs. 175, 176A, 176B, 176D, 176G, 176I and 176J.

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